21006

HUMANA Pain Management
Prior Authorization Request Form

** Please complete and Fax this request form along with all supporting clinical documentation to OrthoNet at 1-888-605-5345.

NOTE: The information transmitted is intended only for the person or entity to which it is addressed and may contain CONFIDENTIAL material. If you receive this material/information in error, please contact the sender and delete or destroy the material/information.

PROVIDER INFORMATION:

Fax Date: __ / __ / ____

Number of pages faxed : (including this cover page)

Provider Name

Street Address

City

State

ZIP

Telephone Number ( ) -

National Provider Identifier (NPI)

○ Facility NPI Number

○ Individual NPI Number

Fax Number ( ) -

Provider Tax ID Number

○ Facility Tax ID Number

○ Individual Tax ID Number

PATIENT INFORMATION:

First Name

Last Name

Date of Birth __ / __ / ____
Month Day Year

HUMANA Member ID Number

1. Primary Diagnosis Code

Please Select Spinal Region(s) which applies: ○ Cervical ○ Thoracic ○ Lumbar ○ Sacral

2. Requested Procedure(s): ○ Epidural Steroid Injection ○ Facet Joint Injection

Facet Medial Branch Nerve Block: ○ Local ○ Steroid ○ RFA

Spinal Cord Stimulator: ○ Trial ○ Implant

Pain Pump: ○ Trial (Narcotic - Baclofen - Prialt) ○ Implant (Narcotic - Baclofen - Prialt)

3. Please provide exact Epidural Levels or Facet Joint Levels or exact Medial Branch Nerves to be injected

(Must be completed in order to process request)

○ Right ○ Left ○ Bilateral

4. Previous Epidural or Facet Injections(s)? ○ Yes ○ No

If yes, ____% Pain Relief lasted ____ weeks from last (Epidural or Facet injection) performed on Date:____________

CPT Code(s):

Anticipated Date of Service(s) __ / __ / ____
Month Day Year

Requested Facility for Surgery/Procedure(s) *(If Applicable)*

City

State

Facility Tax ID Number

For Internal Office Use Only

○A ○S ○P

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